SOCIAL SECURITY ADMINISTRATION

Independence, MO 64056

CERTIFICATION OF TRUE COPY

Pursuant to the provisions of Title 42, United States Code, Section 904, and the authority vested in me by 42 U.S.C. 902.

I hereby certify that I do have legal custody of certain records, documents and other information published and maintained by the Social Security Administration, pursuant to Title 42, United States Code, Section 405, and that the annexed are true copies thereof from such documents in my custody as aforesaid.

I further certify that all signatures of Social Security Administration annexed documents are genuine and made to the signers' official capacity.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the seal of the Social Security Administration to be affixed this 19th day of May 2017.

Petula Traywick,
Supervisory Project Manager,
SSA National Records Center
6000 E. Geospace Dr.
Independence, MO 64056

EXHIBIT E

Form SSA-1841 (01-2011)
Destroy Prior Editions

SOCIAL SECURITY ADMINISTRATION

Independence, MO 64056

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Supervisory Project Manager,
SSA National Records Center
6000 E. Geospace Dr.
Independence, MO 64056

Form SSA-1841 (01-2011)
Destroy Prior Editions

Social Security Administration Region VII
National Records Center
6000 E. Geospace Dr.
Independence, MO 64056

May 19, 2017

Ogletree Deakins Nash Smoak & Stewart
7700 Bonhomme Ave.
Suite 650
St. Louis, MO 63105

These Certified records are for **LaTanya Blevins**, Social Security Number [redacted]

Petula Traywick
Supervisory Project Manager
Social Security Administration
Kansas City Region

January 10, 2013, 18:01
PAGE 1

NH [redacted]

SG-SSA-16

UNIT: HHHHHH

LATANYA D BLEVINS
[redacted]

APPLICATION SUMMARY FOR DISABILITY INSURANCE BENEFITS

On December 5, 2012, we talked with you and completed your application for SOCIAL SECURITY BENEFITS. We stored this information electronically in our records. We are enclosing a summary of your statements.

I APPLY FOR A PERIOD OF DISABILITY AND/OR ALL INSURANCE BENEFITS FOR WHICH I AM ELIGIBLE UNDER TITLE II AND PART A OF TITLE XVIII OF THE SOCIAL SECURITY ACT, AS PRESENTLY AMENDED.

MY NAME IS LATANYA D BLEVINS.

MY SOCIAL SECURITY NUMBER IS [redacted]

MY DATE OF BIRTH IS [redacted]

I AM A CITIZEN OF THE UNITED STATES.

I BECAME UNABLE TO WORK BECAUSE OF MY DISABLING CONDITION ON December 4, 2011.

I AM STILL DISABLED.

NO PREVIOUS APPLICATION HAS BEEN FILED WITH THE SOCIAL SECURITY ADMINISTRATION BY OR FOR ME.

I DO NOT WANT TO FILE FOR SSI.

I HAVE NOT FILED NOR DO I INTEND TO FILE FOR ANY WORKERS' COMPENSATION, PUBLIC DISABILITY OR BLACK LUNG BENEFITS.

I AM NOT ENTITTLED TO NOR DO I EXPECT TO BECOME ENTITLED TO A PENSION OR ANNUITY BASED IN WHOLE OR IN PART ON WORK AFTER 1956 NOT COVERED BY SOCIAL SECURITY.

THE SOCIAL SECURITY ADMINISTRATION AND THE STATE AGENCY REVIEWING MY CLAIM DO HAVE MY PERMISSION TO CONTACT MY EMPLOYER(S).

I NEVER MARRIED OR I HAD NO PREVIOUS MARRIAGES THAT LASTED 10 YEARS OR MORE OR ENDED IN DEATH.

NH [redacted] SG-SSA-16

I DO NOT HAVE ANY CHILDREN UNDER AGE 18; AGE 18-19 ATTENDING ELEMENTARY OR SECONDARY SCHOOL FULL TIME; OR AGE 18 OR OVER AND DISABLED BEFORE AGE 22 WHO MAY BE ELIGIBLE FOR SOCIAL SECURITY BENEFITS ON THIS RECORD. THIS INCLUDES CHILDREN WHO MAY OR MAY NOT BE LIVING WITH ME.

I UNDERSTAND THAT I MUST PROVIDE MEDICAL EVIDENCE ABOUT MY DISABILITY, OR ASSIST THE SOCIAL SECURITY ADMINISTRATION IN OBTAINING THE EVIDENCE.

I UNDERSTAND THAT I MAY BE REQUESTED BY THE STATE DISABILITY DETERMINATION SERVICES TO HAVE A CONSULTATIVE EXAMINATION AT THE EXPENSE OF THE SOCIAL SECURITY ADMINISTRATION AND THAT IF I DO NOT GO, MY CLAIM MAY BE DENIED.

I AUTHORIZE ANY PHYSICIAN, HOSPITAL, AGENCY, OR OTHER ORGANIZATION TO DISCLOSE ANY MEDICAL RECORD OR INFORMATION ABOUT MY DISABILITY TO THE SOCIAL SECURITY ADMINISTRATION OR TO THE STATE DISABILITY DETERMINATION SERVICES THAT MAY REVIEW MY CLAIM OR CONTINUING DISABILITY.

I AUTHORIZE THE SOCIAL SECURITY ADMINISTRATION TO RELEASE ANY INFORMATION ABOUT ME TO A PHYSICIAN OR MEDICAL FACILITY PREPARATORY TO AN EXAMINATION OR TEST. RESULTS OF SUCH EXAMINATION OR TEST MAY BE RELEASED TO MY PHYSICIAN OR OTHER TREATING SOURCE.

I AUTHORIZE THAT INFORMATION ABOUT MY DISABILITY MAY BE FURNISHED TO ANY CONTRACTOR FOR CLERICAL SERVICES BY THE STATE DISABILITY DETERMINATION SERVICES.

I AGREE TO NOTIFY THE SOCIAL SECURITY ADMINISTRATION OF ALL EVENTS AS EXPLAINED TO ME.

REMARKS:
I AGREE WITH THE EARNINGS AS SHOWN ON MY SOCIAL SECURITY STATEMENT.
PREPARER'S INFORMATION:

WORK:FOREIGN-2011=N 2012=N 2013=N USTAXESPD-2011=? 2012=? 2013=?

I KNOW THAT ANYONE WHO MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF MATERIAL FACT IN AN APPLICATION OR FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW BY FINE, IMPRISONMENT OR BOTH. I AFFIRM THAT ALL INFORMATION I HAVE GIVEN IN CONNECTION WITH THIS CLAIM IS TRUE.

MY TELEPHONE NUMBER IS [redacted].

NH [redacted]

SO-SSA-16

SOCIAL SECURITY ADMINISTRATION
IMPORTANT INFORMATION

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

LATANYA D BLEVINS
[redacted]

YOUR APPLICATION FOR SOCIAL SECURITY BENEFITS HAS BEEN RECEIVED AND WILL BE PROCESSED AS QUICKLY AS POSSIBLE.

YOU SHOULD HEAR FROM US WITHIN __ DAYS AFTER YOU HAVE GIVEN US ALL THE INFORMATION WE REQUESTED. SOME CLAIMS MAY TAKE LONGER IF ADDITIONAL INFORMATION IS NEEDED.

IN THE MEANTIME, IF YOU CHANGE YOUR ADDRESS, OR IF THERE IS SOME OTHER CHANGE THAT MAY AFFECT YOUR CLAIM, YOU - OR SOMEONE FOR YOU - SHOULD REPORT THE CHANGE.

We are providing the attached application for your records.

We stored your application information electronically so there is no reason for us to retain a paper copy of your application.

IMPORTANT REMINDER

Penalty of Perjury

You declared under penalty of perjury that you examined all the information on this form and it is true and correct to the best of your knowledge. You were told that you could be liable under law for providing false information.

THE TELEPHONE NUMBERS TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT ARE:

BEFORE YOU RECEIVE A NOTICE ABOUT YOUR CLAIM:

AFTER YOU RECEIVE A NOTICE ABOUT YOUR CLAIM:

SOCIAL SECURITY INFORMATION IS ALSO AVAILABLE TO INTERNET USERS AT WWW.SOCIALSECURITY.GOV.

What You Need To Do

- Review the summary to make sure we recorded your statements correctly.
- If you agree with all your statements, you may keep the information for your records.

NH [redacted] SG-SSA-16

- If you disagree with any of your statements, please contact us within 10 days after receiving this notice to let us know.

ALWAYS GIVE US YOUR CLAIM NUMBER WHEN WRITING OR TELEPHONING ABOUT YOUR CLAIM. IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, WE WILL BE GLAD TO HELP YOU.

WE ARE RETURNING ANY DOCUMENT(S) YOU MAY HAVE SUBMITTED WITH YOUR APPLICATION.

HELPFUL HEALTH CARE WEBSITES

Health Information

The U.S. Department of Health and Human Services provides information on many health topics at www.healthfinder.gov on the Internet. You may wish to visit that site to review that information, which may be helpful to you.

Prescription Drug Assistance Programs

You may be able to get help paying for prescription drugs. To find out what programs are offered by drug companies, state and local governments, and local organizations, please visit www.healthfinder.gov/rxdrug on the Internet.

CLAIMANT
LATANYA D BLEVINS

SOCIAL SECURITY CLAIM NO.
[redacted]

NH [redacted] SG-SSA-16

REPORTING RESPONSIBILITIES FOR DISABILITY INSURANCE BENEFITS

LATANYA D BLEVINS
[redacted]

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAID, AND IN POSSIBLE MONETARY PENALTIES

- You change your mailing address for checks or residence. To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.
- Your citizenship or immigration status changes.
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- You have an unsatisfied warrant for your arrest for a crime or attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year).
- You have an unsatisfied warrant for a violation of probation or parole under Federal or State law.
- Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.
- Custody Change - Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, or changes address.
- Change of Marital Status - Marriage, divorce, annulment of marriage.
- You become entitled to a pension or annuity based on your employment after 1956 not covered by Social Security, or if such pension or annuity stops.
- You return to work (as an employee or self-employed) regardless of the amount of earnings.

NH [redacted] SG-SSA-16

- Your condition improves.
- If you are under age 65 and you apply for or begin to receive Workers' Compensation or another public disability benefit (including Black Lung benefits), or the amount of your present Workers' Compensation or public benefit changes or stops, or you receive a lump sum settlement.

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- Calling us TOLL FREE at 1-800-772-1213;
- If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- Calling, visiting or writing your local Social Security Office at the phone number and address above.

For general information about Social Security, visit our website at www.socialsecurity.gov

For those under full retirement age, the law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

NOTICE ABOUT DOCUMENTS

We recommend that you keep all documents you submitted to us.
___ We are returning the documents you submitted with this claim.

Collection and Use of Information From Your Application -
Privacy Act Notice / Paperwork Reduction Act Notice

The Social Security Administration is authorized to collect the information requested on this form under sections 202, 205 and 223 of the Social Security Act. The information you provide will be used by the Social Security Administration to determine if you or a dependent is eligible to insurance coverage and/or monthly benefits. You do not have to give us the requested information. However, if you do not provide the information, we will be unable to make an accurate and timely decision concerning your entitlement or a dependent's entitlement to benefit payments.

NH [redacted] SG-SSA-16

The information you provide may be disclosed to another Federal, State or local government agency for determining eligibility for a government benefit or program, to a Congressional office requesting information on your behalf, to an independent party for the performance of research and statistical activities, or to the Department of Justice for use in representing the Federal Government.

We may also use this information when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. 3507 as amended in section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 6401 Security Blvd. Baltimore MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

SOCIAL SECURITY ADMINISTRATION

Refer To: [redacted]

Office of Disability Adjudication and Review
SSA ODAR Hearing Ofc
1285 Fern Ridge Pkwy
Ste 100
Creve Coeur, MO 63141

Date: November 13, 2013

Latanya D. Blevins
[redacted]

Notice of Attorney Advisor Decision – Fully Favorable

I carefully reviewed the facts of your case and made the enclosed fully favorable decision on your application for a period of disability and disability insurance benefits. I found that your disability began on December 4, 2011. I explain the basis for my decision in the attached decision. Please read this notice and my decision.

Another office will process my decision. That office may ask you for more information. If you do not hear anything within 60 days of the date of this notice, please contact your local office. The contact information for your local office is at the end of this notice.

If You Agree With My Decision

If you agree with my decision, you will not have a hearing with an administrative law judge.

If You Disagree With My Decision

If you disagree with my decision, you may still have a hearing with an administrative law judge. If you still want to have a hearing, you or your representative must ask us to continue with your request for a hearing. You must make your request in writing. Mail your request to the address shown at the top of this notice. Please put the Social Security number shown above on any request you make. If you need help, you may go to any Social Security or hearing office.

If you ask for further review of a favorable decision, an administrative law judge will consider the entire case record including the decision. Further review may result in a new decision that is less favorable or unfavorable to you.

Time Limit For Asking to Continue With A Hearing

You must ask us to continue with your hearing request **within 60** days after you receive this notice. We assume you received this notice five days after the date of the notice unless you show you did not get it within five days. If your request to continue with your hearing is timely, you will have a hearing. We will give you more time if you show that you had good cause, or a good

See Next Page

reason, for missing the deadline.

The Appeals Council May Review My Decision On Its Own

The Appeals Council may review my decision even if you do not appeal. They may decide to review my decision within 60 days after the date of the decision. The Appeals Council will mail you a notice of review if they decide to review my decision.

If the Appeals Council does not review my decision on its own and you have not asked us to continue with your hearing request, my decision will become final. We will change a final decision only under special circumstances. You will not have the right to Federal court review.

If You Have Any Questions

We invite you to visit our website located at www.socialsecurity.gov to find answers to general questions about social security. You may also call (800) 772-1213 with questions. If you are deaf or hard of hearing, please use our TTY number (800) 325-0778.

If you have any other questions, please call, write, or visit any Social Security office. Please have this notice and decision with you. The telephone number of the local office that serves your area is (866)931-8349. Its address is:

Social Security
11733 West Florissant
Florissant, MO 63033-6744

Bill Brady
Attorney Advisor

Enclosures:
Decision Rationale

cc:

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

DECISION

IN THE CASE OF

Latanya D. Blevins
(Claimant)

(Wage Earner)

CLAIM FOR

Period of Disability and Disability Insurance Benefits

[redacted]
(Social Security Number)

JURISDICTION AND HISTORY

The claimant protectively filed an application for a period of disability and disability insurance benefits under Title II of the Social Security Act on October 16, 2012, alleging disability since December 4, 2011. The Social Security Administration denied her application. The case is now before the undersigned in response to the claimant's timely filed request for hearing (20 CFR 404.929 *et seq.*).

The evidence of record supports a fully favorable decision. Thus, a hearing need not be held (20 CFR 404.948(a)). The claimant is represented in this matter by Brenda Steck, of Allsup, Inc.

ISSUES AND CONCLUSIONS

At issue is whether the claimant has been disabled under sections 216(i) and 223(d) of the Social Security Act. There is also the issue of whether she meets the insured status requirements of sections 216(i) and 223 of the Social Security Act.

The undersigned finds that the claimant has been disabled within the meaning of the Social Security Act since December 4, 2011. The undersigned also finds that she met the insured status requirements of the Social Security Act on December 4, 2011.

APPLICABLE AUTHORITY

The Social Security Act defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months. Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 404.1520(a)). The steps are followed in order. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

See Next Page

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity (20CFR 404.1520(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. If an individual engages in SGA, she is not disabled regardless of how severe her physical or mental impairments are and regardless of her age, education, or work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20 CFR 404.1520(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. If the claimant does not have a severe medically determinable impairment or combination of impairments, she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

At step three, the undersigned must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, and 404.1526). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement (20 CFR 404.1509), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the undersigned must first determine the claimant's residual functional capacity (20 CFR 404.1520(e)). An individual's residual functional capacity is her ability to do physical and mental work activities on a sustained basis despite limitations from her impairments. In making this finding, the undersigned must consider all of the claimant's impairments, including impairments that are not severe (20 CFR 404.1520(e) and 404.1545; SSR 96-8p).

Next, the undersigned must determine at step four whether the claimant has the residual functional capacity to perform the requirements of her past relevant work (20 CFR 404.1520(f)). If the claimant has the residual functional capacity to do her past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 404.1520(g)), the undersigned must determine whether the claimant is able to do any other work considering her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, she is not disabled. If the claimant is not able to do other work and meets the duration requirement, she is disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 404.1512(g) and 404.1560(c)).

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FINDINGS OF FACT AND CONCLUSIONS OF LAW

The claimant is currently thirty-seven years old. She alleges disability since December 4, 2011 due to multiple sclerosis and Raynaud's syndrome (Exhibits 3D; 4E). The undersigned considered the record and finds as follows:

1. The claimant met the insured status requirements of the Social Security Act on December 4, 2011 (Exhibit 7D).

2. The claimant has not engaged in substantial gainful activity since December 4, 2011 (20 CFR 404.1520(b) and 404.1571 *et seq.*).

She received income through her former employer in the post-December 3, 2011 period, but the income was private disability benefits (Exhibits 1D; 6D).

3. The claimant has the following severe impairment: multiple sclerosis (20 CFR 404.1520(c)).

4. The claimant's condition has not met or medically equaled a listing in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525 and 404.1526).

5. Since December 4, 2011, the claimant has had the residual functional capacity to lift or carry twenty pounds occasionally and ten pounds frequently, and to sit five hours in an eight-hour day, but she has only been able to stand and/or walk a total of less than two hours in an eight-hour day, has required an at-will sit/stand option, has been unable to perform repetitive hand motion tasks or operate foot controls on a repetitive basis, has been unable to climb, balance, stoop, crouch, kneel or crawl, and has had to avoid exposure to extreme temperatures and unprotected heights. This constitutes a narrow range of light work.

In making this finding, the undersigned considered symptoms and the extent to which they can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 404.1529 and SSRs 96-4p and 96-7p. The undersigned also considered opinion evidence in accordance with the requirements of 20 CFR 404.1527 and SSRs 96-2p, 96-5p, 96-6p and 06-3p.

The claimant stated that she has been unable to work because of joint and muscle pain, numbness and a tingling sensation about her feet; pain, numbness and swelling about her hands; fatigue and weakness. She asserted that she has been unable to stand, walk or sit for a prolonged period and that she has difficulty using her hands. She also asserted that she has difficulty lifting objects, reaching, squatting, kneeling and climbing stairs, as well as remembering things. She noted that there are times when spends most of her day lying down (Exhibit 5E).

The medical evidence supports the claimant's allegations. In April 2013, Barbara Green, M.D., a treating physician, opined that the claimant could lift or carry up to twenty pounds on an

See Next Page

occasional basis and up to ten pounds on a frequent basis, but that she could only sit five hours in an eight-hour day, that she could only stand and/or walk a total of less than two hours in an eight-hour day, and that she required an at-will sit/stand option. She further opined that the claimant could not perform repetitive hand motion tasks, that she could not repetitively operate foot controls, that she could not climb, balance, stoop, crouch, kneel or crawl, and that she should avoid exposure to extreme temperatures and unprotected heights. Dr. Green attributed the claimant's limitations to multiple sclerosis, explaining that it has been characterized by daily symptoms of extremity weakness, hand pain and wrist pain, and that other symptoms have included disequilibrium and debilitating fatigue (Exhibit 5F).

Dr. Green's opinions are given considerable weight because they are consistent with her treatment notes (*see* Exhibit 1F). They are also consistent with other medical evidence: a magnetic resonance image of the claimant's brain, taken in May 2011, showed a demyelinating process with several white matter lesions, while February 2012 magnetic resonance image of her cervical spine showed several spinal cord lesions (Exhibit 1F). Moreover, reports dated 2012 from David Schoenwalder, M.D., a treating physician, indicate that the claimant experienced profound fatigue and, and, in November 2012, the doctor noted that the claimant "is still permanently disabled" (Exhibits 2F; 4F).

Other evidence of record supports the claimant as well. In particular, the good work ethic that her earnings record reflects indicates she probably would be working if she were not, in fact, disabled (Exhibit 5D).

Eduardo Ulloa, M.D., a State-agency physician who reviewed the record in January 2013, opined that the claimant could sustain a wide range of light work (Exhibit 1A). However, greater weight is given to Dr. Green's opinions because her relationship with the claimant provided her greater insight into the claimant's condition.

6. The claimant has been unable to perform her past relevant work (20 CFR 404.1565).

She has past relevant work experience as a telephone consultant/representative, collection agent and medical assistant (Exhibit 1E). These jobs require an ability to sustain an eight-hour day on a regular and continuing basis.

7. The claimant is a younger individual (20 CFR 404.1563).

8. The claimant has a college education (20 CFR 404.1564).

9. A significant number of jobs have not existed for the claimant in the national economy since December 4, 2011 (20 CFR 404.1560(c) and 404.1566).

In determining whether a successful adjustment to other work can be made, the undersigned must consider the claimant's residual functional capacity, age, education and work experience in conjunction with the medical-vocational rules in 20 CFR Part 404, Subpart P, Appendix 2. If the claimant can perform all or substantially all of the exertional demands at a given level of exertion, the medical-vocational rules direct a conclusion of either disabled or not disabled

See Next Page

depending upon the claimant's profile (SSR 83-11). When the claimant cannot perform substantially all of the exertional demands of work at a given level of exertion, or has nonexertional limitations, the medical-vocational rules are used as a framework for decision-making unless the applicable rule directs a conclusion of disabled without considering the additional limitations (SSRs 83-12 and 83-14).

If the claimant had the residual functional capacity to perform the full range of light work, a finding of not disabled would be directed by medical-vocational rule 202.21. However, her limitations in sitting, standing and walking so narrow the range of work she might perform that a finding of disabled is appropriate within the framework of this rule. *See* Social Security Ruling 96-8p (a residual functional capacity must be sustainable eight hours a day, five days a week, or an equivalent schedule).

10. The claimant has been disabled within the meaning of the Social Security Act since December 4, 2011 (20 CFR 404.1520(g)).

DECISION

The claimant's application for a period of disability and disability insurance benefits, protectively filed on October 16, 2012, is granted. She has been disabled under sections 216(i) and 223(d) of the Social Security Act since December 4, 2011.

/s/ Bill Brady
Bill Brady
Attorney Advisor

November 13, 2013
Date

Disability Determination Explanation

EXHIBIT NO. 1A
~~PAGE: 1 OF 8~~

CLAIMANT INFORMATION

This Disability Determination Explanation is for the *DIB* claim at the *Initial* level.

CLAIMANT INFORMATION

Name: Latanya D Elevins
SSN: [redacted]
Phone Number: [redacted]
Secondary Phone Number
Address:

Mailing	Residence
[redacted]	[redacted]

Claimant Gender: F
Self Reported Height: 65 inches
Self Reported Weight: 185.0 lbs
Special Indications: None.

RELEVANT DATES

Below table represents the Relevant Dates

Date of Birth	Current Age	AOD	Age at AOD	DFI	DLI	Age at DLI
[redacted]	[redacted] years [redacted] months (Younger person)	12/04/2011	35 years 7 months (Younger person)	04/01/2007	12/31/2016	

Does the individual have an attorney/appointed representative? No

ALLEGATIONS OF IMPAIRMENTS

The individual filed for Initial claim for disability on *10/16/2012* due to the following illnesses, injuries, or conditions:

Multiple sclerosis
RAYNAUDS SYNDROME

The individual alleges inability to function and/or work as of

12/04/2011

TECHNICAL ISSUES

Is the individual working?

No

EXHIBIT NO. 5E
PAGE: 1 OF 13

January 14, 2013

DISABILITY DETERMINATION SERVICES
ATTN DEBBIE
DISABILITY DETERMINATION SRVCS
2530 S CAMPBELL AVE STE1
SPRINGFIELD MO 65807-3539

RE: Latanya Blevins
SSN: [redacted]

Dear Claims Examiner:

I am enclosing Function and Suppl for wage earner Latanya Blevins, SSN [redacted]. Latanya Blevins has a disability claim pending in your office. My SSA-1696 is on file.

My mailing address is provided. For more information, please call our Customer Information Center at (800) 560-1410.

Sincerely,

Claimant Representative

JQD/kms

Latanya Blevins
[redacted]

FUNCTION REPORT - ADULT

Section A: General Information

1. Name of disabled person: Latanya Blevins 2. SSN: [redacted]

3. Daytime Telephone Number: [redacted]

4. Where do you live?

☒ House ☐ Mobile Home ☐ Recreational Vehicle ☐ Apartment ☐ Condominium

☐ Town House ☐ Hotel ☐ Shelter ☐ Assisted Living Facility ☐ Other:

5. With whom do you live?

☐ Alone ☒ With Family ☐ With Friends ☐ Other – Explain:

Section B: Information About Daily Activities

6. Describe what you do from the time you wake up until going to bed.
I get up at 5:30 a.m. and use the restroom. I lay back down and rest for an hour. I make and eat breakfast. Some days, I spend the day lying in bed and resting. Other days, I spend the day reading, watching TV, and doing light chores. I often drive places to get out of the house. I make and eat lunch around 1:00 or 1:30 p.m. and dinner between 7:00 and 8:00 p.m. I spend the evening talking with my family or watching TV. I go to bed around 9:30 or 10:00 p.m.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☒ No

If "YES," for whom do you care, and what do you do for them?
N/A

8. Do you take care of pets or other animals? ☒ Yes ☐ No

If "YES," what do you do for them?
I put down food and water for my dog. I also let the dog outside as needed.

9. Does anyone help you care for other people or animals? ☐ Yes ☒ No

If "YES," who helps, and what do they do to help?
N/A

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?
I can no longer work, run for exercise, type, or multitask.

11. Do the illnesses, injuries, or conditions affect your sleep? ☒Yes ☐No

If "YES," how?
I have difficulty staying asleep due to pain and frequent restroom use. I sometimes wake up for no reason at all. I can only sleep for a couple of hours at time.

12. Personal Care

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress: I sit down to get dressed to avoid standing. I have difficulty using my hands to button buttons, snap snaps, and to zip zippers. I wear comfortable clothes that are easier to get on and off.

Bathe: I take quick showers to avoid standing for long periods of time.

Care for hair: I am able to care for my hair.

Shave: I am able to shave.

Feed self: I am able to feed myself.

Use the toilet: I am able to use the toilet.

Other: N/A

b. Do you need any special reminders to take care of personal needs and grooming?
☐ Yes ☒ No

If "YES," what types of help or reminders are needed?
Please reference my response to 12a.

c. Do you need help or reminders taking medicine? ☐Yes ☒No

If "YES," what kind of help do you need?
N/A

Latanya Blevins
[redacted]

13. Meals

a. Do you prepare your own meals? ☒ Yes ☐ No

If "YES," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses)
I fix simple crock pot, oven baked meals, and salads.

How often do you prepare food or meals? (For example, daily, weekly, monthly)
☐ Daily
☒ Weekly
☐ Monthly

How long does it take you?
☐ 0-5 minutes
☐ 6-15 minutes
☐ 16-30 minutes
☒ 31+ minutes

Any changes in cooking habits since the illness, injuries, or conditions began?
I do not enjoy cooking as much as I did in the past. I used to cook every meal during the day. I avoid lifting full pots and pans. I often wear glove to help me handle pots and pans because I have trouble feeling the temperature of objects. I rotate between sitting and standing when I cook because standing for long periods of time is difficult.

b. If "No," explain why you cannot or do not prepare meals.
N/A

14. House and Yard Work

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)
Please reference my response to 14b

b. How much time does it take you, and how often do you do each of these things?

Chore	How much time	How often
Mop	20 minutes	Every other day
Sweep	20 minutes	Every other day
Clean the bathroom	35 to 40 minutes	Weekly
Vacuum	15 minutes	Twice a week

c. Do you need help or encouragement doing these things? ☐ Yes ☒ No

If "YES," what help is needed?
N/A

Latanya Blevins
[redacted]

d. If you don't do house or yard work, explain why not.
N/A

15. Getting Around

a. How often do you go outside?

- ☐ Once a month
- ☐ A few times a month
- ☐ 1-3 days per week
- ☒ 4-6 days per week
- ☐ Daily
- ☐ Never

If you don't go out at all, explain why not.
N/A

b. When going out, how do you travel?

- ☐ Walk
- ☒ Drive a car
- ☐ Ride in a car
- ☐ Other (Explain):
- ☐ Ride a bicycle
- ☐ Use public transportation

c. When going out, can you go out alone? ☒ Yes ☐ No

If "NO," explain why you can't go out alone?
N/A

d. Do you drive? ☒ Yes ☐ No

If you don't drive, explain why not.
I have difficulty sitting in the car for long periods of time. I have to get out of the car after 30 minutes of sitting in the car. I must change my grip on the steering wheel frequently when I drive because using my hands is more difficult.

16. Shopping

a. If you do any shopping, do you shop:

☒ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what you shop for:

- ☒ Groceries
- ☒ Household items
- ☐ Clothes
- ☐ Gifts
- ☐ Personal interest items
- ☐ Prescriptions and medical items

c. How often do you shop and how long does it take?

Method of shopping	How often do you shop?	How long does it take?
In stores	Once every two weeks	An hour

At times, I lean on the cart for support because walking is more difficult. I often sit down and take a break when I shop because walking and standing is difficult. I rely on a list to remind me what to buy. I carry the light groceries into the house after I come home. I rely on my family to carry in the heavier grocery bags.

17. Money

a. Are you able to:

Pay Bills	☒ Yes	☐ No
Count Change	☒ Yes	☐ No
Handle a savings account	☒ Yes	☐ No
Use a checkbook/money orders	☒ Yes	☐ No

Explain all NO answers:
N/A

b. Has your ability to handle money changed since the illness, injuries, or conditions began? ☐ Yes ☒ No

If "YES," explain how the ability to handle money has changed.
N/A

18. Hobbies/Interests

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)
I read, watch TV, and play board games.

b. How often and how well do you do these things?
I read and watch TV a few days a week. I have trouble sitting for long periods of time to read and watch TV. I turn the TV up louder now so that I can hear it easier. I play board games once a week. I have trouble sitting for long periods of time to play games.

c. Describe any changes in these activities since the illness, injuries, or conditions began.
I turn the TV up louder now. I get up frequently when I read, watch TV, and play games now.

19. Social Activities

a. Do you spend time with others? (In person, on the phone, on the computer, etc.)
☒ Yes ☐ No

If "YES," describe the kinds of things you do with others.
I spend time with my family daily and friends two or three times a month.

How often do you do these things?
Please see my answer above.

b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)
I go to church once a week. Our church service is short, so I am able to sit through the service. I go out to eat with my friends two or three times a month. I am able to go out to eat with friends without difficulty.

Do you need reminded to go places? ☐ Yes ☒ No ☐ N/A

How often do you go and how much do you take part?
Please see my answer above.

Do you need someone to accompany you? ☐ Yes ☒ No ☐ N/A

c. Do you have any problems getting along with family, friends, neighbors, or others?

☐ Yes ☒ No
If "YES," explain:
Please refer to my response in question 20a-getting along with others.

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.
I am not able to do sustain physical activities with friends and family anymore. I do not go out and do things with people as often as I did before my condition. I do not have the energy to do things with people as much as I did in the past.

Latanya Blevins
[redacted]

Section C. Information About Abilities

20a. Check any of the following items that your illnesses, injuries, or conditions affect:

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift (how many pounds), or you can only walk (how far)

☒ Lifting: I have difficulty lifting and carrying objects due to joint and muscle pain, numbness and tingling in my feet, pain, numbness, and swelling in my hands, fatigue, and weakness.
☒ Squatting: I try to avoid squatting due to joint pain, specifically in my knees.
☐ Bending:
☒ Standing: I have difficulty standing for long periods of time due to numbness and tingling in my feet, joint and muscle pain, fatigue, and weakness.
☒ Reaching: I have difficulty reaching for more than a few seconds due to numbness in my hands. My hands feel very heavy when I reach.
☒ Walking (20c): I have trouble walking for long periods of time due to joint and muscle pain, numbness and tingling in my feet, fatigue, and weakness. I am able to walk for 10 or 15 minutes before I need to stop and rest. I need to rest for about five minutes before I can continue.
☒ Sitting: I have problems sitting for long periods of time due to joint and muscle pain. I try to avoid sitting for more than an hour at a time because of the pain.
☒ Kneeling: I try to avoid kneeling due to joint pain, specifically in my knees.
☐ Talking:
☒ Hearing: I have hearing loss in both of my ears. The hearing in my right ear is worse than my left. I must turn the TV volume up louder than before. I talk to people on speaker phone because putting the phone up to my ear muffles the sound.
☒ Stair Climbing: I have trouble climbing stairs due to joint and muscle pain, numbness and tingling in my feet, fatigue, and weakness. The pain in my knees makes climbing stairs very difficult, especially when the weather is cold.
☐ Seeing:
☒ Memory: At times, I have trouble recalling information. I forget recent conversations and instructions. I rely on reminders to remember appointments and important tasks.
☒ Completing Tasks (20e): I have trouble multitasking because I can only focus on one task at a time. It takes me longer to finish tasks because of fatigue. I often take breaks before I can finish tasks.
☐ Concentration (20d):
☐ Understanding:
☒ Following Instructions (20 f-g): I write down spoken instructions so that I remember what I need to do.
☒ Using Hands: I have trouble using my hands due to pain, numbness, and swelling in my hands. My ability to write, type, and handle objects is much more limited now.
☐ Getting along with others:

b. Are you: ☒ **Right Handed?** ☐ **Left Handed?**

c. How far can you walk before needing to stop and rest?
Please refer to my response in question 20a-walking.

If you have to rest, how long before you can resume walking?
Please refer to my response in question 20a-walking.

d. For how long can you pay attention?
Please refer to my response in question 20a-concentration.

e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie?)
Please refer to my response in question 20a-completing tasks.

f. How well do you follow written instructions? (for example, a recipe)
Please refer to my response in question 20a-following instructions.

g. How well do you follow spoken instructions?
Please refer to my response in question 20a-following instructions.

h. How well do you get along with authority figures? (for example, police, bosses, landlords or teachers)
I am able to get along with authority figures.

i. Have you ever been fired or laid off from a job because of problems getting along with other people? ☐ Yes ☒ No

If "YES," please explain.
N/A

If "YES," give the name of employer.
N/A

j. How well do you handle stress?
Whenever I feel stressed, I have an attack, which causes my physical symptoms to worsen. I experience increased pain, numbness, and fatigue. I try to avoid as much stress as I can to avoid these attacks.

k. How well do you handle changes in routine?
At times, I feel stressed whenever I have to adapt to change. I can normally handle change without difficulty.

l. Have you noticed any unusual behavior or fears? ☐ Yes ☒ No
If "YES," please explain.
N/A

Latanya Blevins
[redacted]

21. Do you use any of the following? *(Check all that apply)*

- ☐ Crutches
- ☐ Cane
- ☐ Hearing Aid
- ☐ Walker
- ☐ Brace/Splint
- ☐ Other (Explain):
- ☒ Glasses/Contact Lenses
- ☐ Wheelchair
- ☐ Artificial Limb
- ☐ Artificial Voice Box

Which of these were prescribed by a doctor?
Please see my answer below.

When was it prescribed?

Assistive Device	Was it prescribed?	When was it prescribed?
Glasses	☒ Yes ☐ No	A month ago
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

When do you need to use these aids?
I wear glasses at all times.

Remarks
(Use this section for any added information you did not show in earlier parts of this form.)

I RECEIVED HELP IN COMPLETING THIS FORM FROM MY NON-ATTORNEY REPRESENTATIVE.

Form Completed By:
Phone #: (800) 560-1410
Address: 300 Allsup Place
Belleville, IL 62223
Relationship to Claimant: Non-Attorney Representative

CLAIMANT REPRESENTATIVE'S SIGNATURE

January 14, 2013
DATE

Latanya Blevins
[redacted]

Missouri Supplemental Questionnaire

CLAIMANT NAME	SOCIAL SECURITY NUMBER	CASE NUMBER
Latanya Blevins	[redacted]	

PLEASE HELP US WITH YOUR CLAIM BY ANSWERING QUESTIONS ABOUT YOUR CONDITION. IF YOU NEED MORE SPACE FOR ANSWERS, PLEASE ATTACH ADDITIONAL PAGES.

IN THE FOLLOWING QUESTIONS, TELL US HOW YOUR SYMPTOMS AFFECT YOUR ABILITY TO DO NORMAL ACTIVITIES. SYMPTOMS MAY INCLUDE (FOR EXAMPLE), PAIN, FATIGUE, SHORTNESS OF BREATH, ETC.

1. Are you currently working? Yes [No]
   If so, please explain/describe.
   N/A

2. Have you received any treatment since you filed your claim? [Yes] No
   Do you have any upcoming appointments? [Yes] No
   If yes to either of these questions, please complete below:

Doctor/Hospital	Date Last Visit	Date Next Visit	Address/Phone Number	Type of Treatment
Dr. Schoenwalder	11/2/2012	PRN	Suite 310 15945 Clayton Road Clarkson Valley, MO 63011 (636) 256-5350	Follow up
Dr. Green	8/30/2012	3/12/2013	1176 Town and Country Commons Chesterfield, MO 63017 (636) 893-1260	Routine exam

3. Have you been a patient at a Veterans Administration (VA) facility, and had a Disability Compensation or Disability Pension evaluation there. Yes [No]
   If yes, please complete below.

Date Performed	Address	Compensation/Pension

Latanya Blevins
[redacted]

4. Are you currently receiving Medicaid benefits? Yes [No]
If No, have you applied for Medicaid benefits within the past year? Yes [No]

Please list any examinations that were scheduled for you as part of the Medicaid application process.

Doctor	Address/Phone Number	Date Performed
N/A	N/A	N/A

5. Please list any new medication or changes in medications you are taking for your symptoms, since you applied for disability:

Name/Medicine	Doctor	Dosage	How often
N/A	N/A	N/A	N/A

6. Do you play video games, puzzles, or use a computer? Yes [No]
How long at one sitting?
N/A

7. Do you have or have you ever had a valid driver's license? [Yes] No
If No, why?
N/A

Are you currently able to drive? [Yes] No
If No, why?
N/A

8. Please give names, addresses, and phone numbers of up to three people other than your doctors, who know about you and your condition:

Name	Complete Address	Daytime Phone Number
Doris Blevins	[redacted]	[redacted]

May we contact the individuals above? [Yes] No

Latanya Blevins
[redacted]

I RECEIVED HELP IN COMPLETING THIS FORM FROM MY NON-ATTORNEY REPRESENTATIVE.

Form Completed By:
Phone #: (800) 560-1410
Address: 300 Allsup Place
Belleville, IL 62223
Relationship to Claimant: Non-Attorney Representative

CLAIMANT REPRESENTATIVE'S SIGNATURE

January 14, 2013
DATE

DISABILITY REPORT - ADULT - Form SSA-3368

EXHIBIT NO. 4E
PAGE: 1 OF 8

(3368) Section 1 - Information About the Disabled Person

1.A. Name (First, Middle Initial, Last) **Latanya D Blevins**

1.B. Social Security Number [redacted]

1.C. Mailing Address (Street or PO Box) [redacted]
Include apartment number if applicable,
City, State/Province, Zip/Postal Code,
Country (if not USA)

1.D. Email Address

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.
Phone number [redacted]
Check this box if you do not have a phone or number where we can leave a message

1.F. Alternate Phone Number - another number where we may reach you, if any
Alternate phone number

1.G. Can you speak and understand English? **Yes**
If no, what language do you prefer?
NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? **Yes**

1.I. Can you write more than your name in English? **Yes**

1.J. Have you used any other names on your medical or educational records? **No**
Examples are maiden name, other married name or nickname.
If yes, please list them here:

(3368) Section 2 - Contacts

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)
2.B. Relationship to you:
2.C. Daytime Phone Number (as described in 1.E. above)
2.D. Mailing Address (Street or PO Box)
Include apartment number or unit if applicable,
City, State/Province, Zip/Postal Code,
Country (if not USA)

If no, w[illegible] language is prefer[illegible]

2.F. Who is completing this report? **Someone else (Complete the rest of Section 2 below)**

2.G. Name (First, Middle Initial, Last)

2.H. Relationship to Person Applying:

2.I. Daytime Phone Number

2.J. Mailing Address (Street or PO Box)
Include apartment number or unit if applicable
City, State/Province, Zip/Postal Code,
Country (if not USA)

(3368) Section 3 - Medical Conditions

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1. **Multiple sclerosis**
2. **RAYNAUDS SYNDROME**

3.B. What is your height without shoes? **5' 5"**

3.C. What is your weight without shoes? **185 lbs.**

3.D. Do your conditions cause you pain or other symptoms? **Yes**

(3368) Section 4 - Work Activity

4.A. Are you currently working?

No, I have stopped working (Go to question 4.C. below)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year)

12/04/2011

Why did you stop working?

Because of my condition(s).

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours or rate of pay)

No (Go to Section 5, Education and Training)

vacation, or disability pay. (We may contact you for more information.)

IF YOU ARE CURRENTLY WORKING:

1.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

1.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1000 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

(3368) Section 5 - Education and Training Information

5.A. Check the highest grade of school completed. **4 or more years of college**

Date Completed: **5/9/2007**

5.B. Did you attend special education classes? **No** (Go to 5.C.)

5.C. Have you completed any type of specialized job training, trade or vocational school?

No

(3368) Section 6 - Job History

5.A. List the jobs (up to 5) that you had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate Of Pay	
		From mm/yy	To mm/yy			Amount	Frequency
COLLECTION AGENT	FINANCIAL SERVICE	OCTOBER 2000	OCTOBER 2001	8	5		Hour
MEDICAL ASSISTANT	DOCTORS OFFICE	MARCH 1999	SEPTEMBER 2000	6	4		Hour
SENIOR CONSULTANT	WIRELESS NETWORK SERVICE CENTER	JANUARY 2007	DECEMBER 2011	9	5		Hour
SERVICE REPRESENTATIVE	WIRELESS NETWORK SERVICE CENTER	AUGUST 2004	JANUARY 2007	9	5		Hour
SUPPLY CLERK	ARMY	JUNE 1994	APRIL 1998	12	7		Month

had more than one job in the last 15 years before I became unable to work. Do not answer the questions on page 5. Go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

5.B. Describe this job. What did you do all day?

5.C. In this job, did you:
Use machines, tools or equipment?
Use technical knowledge or skills?
Do any writing, complete reports, or perform any duties like this?

5.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk		Stoop (Bend down & forward at the waist)		Handle large objects	
Stand		Kneel (Bend legs to rest on knees)		Write, type or handle small objects	
Sit		Crouch (Bend legs & back down & forward)		Reach	
Climb		Crawl (Move on hands & knees)			

5.E. Lifting and carrying (Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job):

5.F. Check **heaviest** weight lifted:

5.G. Check weight **frequently** lifted (by frequently, we mean from 1/3 to 2/3 of the workday.):

5.H. Did you supervise other people in this job?
How many people did you supervise?
What part of your time did you spend supervising people?
Did you hire and fire employees?

5.I. Were you a lead worker?

(3368) Section 7 - Medicines

---

7. Are you taking any medicines (prescription or non-prescription)?

No (Go to Section 8 - Medical Treatment)

[3368] Section 8 - Medical Treatment

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

8.A. For any **physical** condition(s)?

Yes

8.B. For any **mental** condition(s) **(including emotional or learning problems)**?

No

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

Tell us who may have medical records about any of your physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	
Name of health care professional who treated you	**BARBARA GREEN DR**

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	**636-893-1260**	Patient ID# (if known)	
Mailing Address	**1176 TOWN AND COUNTRY COMMONS CHESTERFIELD, MO 63017**		

Dates of Treatment

1. Office, Clinic or Outpatient visits		**2. Emergency Room visits** List the most recent date first		**3. Overnight hospital stays** List the most recent date first			
First Visit	**2010**	A.		A. Date in		Date out	
Last Visit	**8/30/2012**	B.		B. Date in		Date out	
Next scheduled appointment (if any)	**3/12/2013**	C.		C. Date in		Date out	

What medical conditions were treated or evaluated?

MULTIPLE SCLEROSIS

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

MONITORS CONDITION, EXAMS, TESTING

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates [illegible]

Check this box if no tests by this provider or at this facility.

EXHIBIT NO. 4E
PAGE: 6 OF 8

Kind of Test	Dates of Tests
Blood test (Not HIV)	4/2012
MRI/CT Scan (HEAD AND SPINE)	4/2012

8.D. Name of Facility or Office	
Name of health care professional who treated you	DAVID SCHOENWALDER DR

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	636-256-5350	Patient ID# (if known)	
Mailing Address	STE 310 15945 CLAYTON ROAD CLARKSON VALLEY, MO 63011		

Dates of Treatment

1. Office, Clinic or Outpatient visits		2. Emergency Room visits List the most recent date first		3. Overnight hospital stays List the most recent date first			
First Visit	2006	A.		A. Date in		Date out	
Last Visit	10/2/2012	B.		B. Date in		Date out	
Next scheduled appointment (if any)	11/2/2012	C.		C. Date in		Date out	

What medical conditions were treated or evaluated?

GENERAL HEALTH CONCERNS, RAYNAUDS SYNDROME

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

MONITORS CONDITION, EXAMS, TESTING

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.

Check this box if no tests by this provider or at this facility.

Kind of Test	Dates of Tests
Blood test (Not HIV)	10/2/2012

(3368) Section 9 - Other Medical Information

earning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

No (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11.)

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

(3368) Section 10 - Vocational Rehabilitation, Employment, or Other Support Services

10.A. Have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An individualized education program (IEP) through a school (if a student age 18 - 21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

(3368) Section 11 - Remarks

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

CONDITION DESCRIPTION: IN 10/2009, I WAS SUFFERING FROM EXCESSIVE DIARRHEA. I WENT TO THE DOCTOR AND I WAS TOLD THAT I HAD DIVERTICULITIS. I ADJUSTED MY DIET AS TOLD AND MY SYMPTOMS STARTED TO BECOME WORSE. I WENT BACK TO SEE MY DOCTOR IN 11/2009 AND I STARTED TO HAVE NUMBNESS IN MY LEGS AND FEET. BOTH OF MY HANDS STARTED TO CURL AND I BEGAN TO DROP ITEMS. I THEN STARTED TO WALK WITH A LIMP. I WENT FOR FURTHER TESTING AND IN 11/2009, I WAS DIAGNOSED WITH MULTIPLE SCLEROSIS. I STARTED TREATMENT FOR MY MS IN 12/2009. WITH THE TREATMENT, I STARTED TO SUFFER WITH SEVERE SIDE EFFECTS. I THEN LOOKED INTO NATURAL MEDICINE TO CONTROL MY SYMPTOMS. IN 2010, I WAS DIAGNOSED WITH RAYNAUDS SYNDROME. I SUFFER WITH CONSTANT PAIN THROUGHOUT MY MUSCLES AND JOINTS. THE PAIN IS MOST SEVERE IN MY HANDS AND KNEES. I EXPERIENCE PAIN IN MY FRONTAL LOBE, WHICH RADIATES INTO MY EARS. DUE TO THE SHOOTING PAIN, I NOW SUFFER WITH HEARING LOSS. I EXPERIENCE FREQUENT MUSCLE SPASMS IN MY NECK. I EXPERIENCE FREQUENT PERIODS OF LIGHTHEADEDNESS AND DIZZINESS WITH INCREASED FATIGUE. I EXPERIENCE FREQUENT WEAKNESS AND EXCESSIVE FATIGUE. I HAVE CONSTANT TINGLING AND NUMBNESS IN MY HANDS AND FEET. I HAVE CONSTANT SWELLING IN MY HANDS. I HAVE LIMITED RANGE OF MOTION AND WEAKNESS IN MY HANDS AND FEET. AFTER THIS FORM IS SUBMITTED, ADDITIONAL SIGNED

EXHIBIT NO. 4E
PAGE: 8 OF 8

Date Report Completed	! ____/____/____ (Month) (Day) (Year)

Form SSA-3368 EDCS

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

[3367] ID/Prior Filings

Identifying Information

1. Name of person(s) on whose Social Security record(s) this claim is being filed:

Latanya D Blevins

His or Her Social Security Number(s): [redacted]

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Female**

Date of Birth: [redacted]

2. Claimant's Alleged Onset Date: **12/04/2011**

3. Potential Onset Date (if different from above):

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

6. Protective Filing Date: **10/16/2012**

Date Last Insured (DIB/Freeze case): **12/31/2016**

Closed Period Case: **No**

Prior Filing Information

7. Prior Filing(s): **No**

If "Yes" and you are not sending the prior folder, enter the following:

[3367] Presumptive

The Presumptive Disability page details are not being displayed here because there is no initial level SSI claim on this case.

[3367] Observations

9. Observations/Perceptions:

How was the Interview Conducted? **No contact with claimant**

Observations. Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.
Application completed by rep online. Forms submitted in the mail

---

(3367) Development

---

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:
SSA-3371:
SSA-3369:
Other:

11. Was medical evidence brought in to the FO by the claimant? **No**
12. Is DDS capability development needed? **No**
Remarks:

Name of Interviewer:
Phone Number: **866-931-2871**
Name of Person Completing Form: **R. Sinclair**
Date: **12/21/2012**

Form SSA-3367 EDCS

EXHIBIT NO. 1E
PAGE: 1 OF 8

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

WORK HISTORY REPORT

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME *(First, Middle Initial, Last)*	B. SOCIAL SECURITY NUMBER
LATANYA DENISE BLEVINS	

C. DAYTIME TELEPHONE NUMBER *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

(314) — Area Code

[redacted] — Number

☑ Your Number ☐ Message Number ☐ None

SECTION 2 - INFORMATION ABOUT YOUR WORK

List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

Job Title	Type of Business	Dates Worked *(Month and Year)*	
		FROM	TO
1. SENIOR CONSULTANT	WIRELESS NETWORK SERVICE CENTER	01/2007	12/2011
2. SERVICE REPRESENTATIVE	WIRELESS NETWORK SERVICE CENTER	08/2004	01/2007
3. COLLECTION AGENT	FINANCIAL SERVICE	10/2000	10/2001
4. MEDICAL ASSISTANT	DOCTORS OFFICE	03/1999	09/2000
5. SUPPLY CLERK	ARMY	06/1994	04/1998
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Work History Report - Form SSA-3369-BK

EXHIBIT NO. 1E
PAGE: 2 OF 8

Give us more information about Job No. 1 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 1 **SENIOR CONSULTANT** **WIRELESS NETWORK SERVICE CENTER**

Rate of Pay	Per (Check One)	Hours per day	Days per week
	☑ Hour ☐ Day ☐ Week ☐ Month ☐ Year	9	5

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

I ANSWERED INBOUND CALLS FROM EXISTING AND POTENTIAL CUSTOMERS. I ADDRESSED THE NATURE OF THE CALL, OFFERED PRODUCTS, APPLIED PAYMENTS AND ADJUSTMENTS TO BILLING. I PROCESSED AND ENTERED OR CANCELLED ORDERS FOR CUSTOMERS. I DOCUMENTED THE NATURE AND SERVICE PROVIDED ON THE CALL. I THEN TRANSFERRED THE CALLS TO OTHER DEPARTMENTS WHEN NEEDED. I COMPLETED SALES, CANCELLATIONS, PROCESSING TIME REPORTS.

In this job, did you:			
	Use machines, tools or equipment?	☐ YES	☑ NO
	Use technical knowledge or skills?	☑ YES	☐ NO
	Do any writing, complete reports, or perform duties like this?	☑ YES	☐ NO

In this job, how many total hours each day did you:

Walk?	0.5 hours	Kneel? *(Bend legs to rest on knees.)*	0 hours (Never)
Stand?	0.5 hours	Crouch? *(Bend legs back down forward.)*	0 hours (Never)
Sit?	8 hours or more	Crawl? *(Bend legs to rest on knees.)*	0 hours (Never)
Climb?	0 hours (Never)	Handle, grab or grasp big objects?	0 hours (Never)
Stoop? *(Bend down and forward at waist.)*	0 hours (Never)	Reach?	8 hours or more
		Write, type or handle small objects?	8 hours or more

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

PAPERS, HEADSET, BINDERS, MANUALS

Check the **heaviest** weight lifted:

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other ____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other ____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☑ NO

How many people did you supervise? ____

What part of your time was spent supervising people? ____

Did you hire and fire employees? ☐ YES ☑ NO

Were you a lead worker? ☐ YES ☑ NO

EXHIBIT NO. 1E
PAGE: 3 OF 8

Give us more information about Job No. 2 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 2 SERVICE REPRESENTATIV WIRELESS NETWORK SERVICE CENTER

Rate of Pay	Per *(Check One)* Hour	Hours per day	Days per week
	☑ Hour ☐ Day ☐ Week ☐ Month ☐ Year	9	5

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

I ANSWERED INBOUND CALLS FROM EXISTING AND POTENTIAL CUSTOMERS. I ADDRESSED THE NATURE OF THE CALL, OFFERED PRODUCTS, APPLIED PAYMENTS AND ADJUSTMENTS TO BILLING. I CANCELLED ORDERS FOR CUSTOMERS. I DOCUMENTED THE NATURE AND SERVICE PROVIDED ON THE CALL. I THEN TRANSFERRED THE CALLS TO OTHER DEPARTMENTS WHEN NEEDED. I COMPLETED SALES, CANCELLATIONS, PROCESSING TIME REPORTS.

In this job, did you: Use machines, tools or equipment? ☐ YES ☑ NO

Use technical knowledge or skills? ☑ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☑ YES ☐ NO

In this job, how many total hours each day did you:

Walk?	0.5 hours	Kneel? *(Bend legs to rest on knees.)*	0 hours (Never)
Stand?	0.5 hours	Crouch? *(Bend legs back down forward.)*	0 hours (Never)
Sit?	8 hours or more	Crawl? *(Bend legs to rest on knees.)*	0 hours (Never)
Climb?	0 hours (Never)	Handle, grab or grasp big objects?	0 hours (Never)
Stoop? *(Bend down and forward at waist.)*	0 hours (Never)	Reach?	8 hours or more
		Write, type or handle small objects?	8 hours or more

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

PAPERS, HEADSET, BINDERS, MANUALS

Check the **heaviest** weight lifted:

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☑ NO

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☑ NO

Were you a lead worker? ☐ YES ☑ NO

EXHIBIT NO. 1E
PAGE: 4 OF 8

Give us more information about Job No. 4 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 4 MEDICAL ASSISTANT DOCTORS OFFICE

Rate of Pay	Per (Check One) Hour	Hours per day	Days per week
	☑ Hour ☐ Day ☐ Week ☐ Month ☐ Year	6	4

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

I DREW BLOOD FROM THE PATIENT, ASSESSED THE BLOOD PRESSURE AND TEMPERATURE. I PROCESSED URINALYSIS SPECIMENS FROM THE PATIENT. I COMPLETED CHARTING FOR THE DOCTOR OF THE FINDINGS IN THE PATIENTS CHART. I USED MEDICAL SUPPLIES AND TESTING MATERIAL TO ASSESS THE PATIENT AND THE SPECIMENS PROVIDED.

In this job, did you:

Use machines, tools or equipment?	☑ YES	☐ NO
Use technical knowledge or skills?	☑ YES	☐ NO
Do any writing, complete reports, or perform duties like this?	☑ YES	☐ NO

In this job, how many total hours each day did you:

Walk?	3 hours	Kneel? *(Bend legs to rest on knees.)*	0 hours (Never)
Stand?	2.5 hours	Crouch? *(Bend legs back down forward.)*	0 hours (Never)
Sit?	0.5 hours	Crawl? *(Bend legs to rest on knees.)*	0 hours (Never)
Climb?	0 hours (Never)	Handle, grab or grasp big objects?	0 hours (Never)
Stoop? *(Bend down and forward at waist.)*	0 hours (Never)	Reach?	5.5 hours
		Write, type or handle small objects?	5.5 hours

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

NEEDLES, CHARTS, SPECIMENS, BLOOD PRESSURE CUFFS, STETHOSCOPE

Check the **heaviest** weight lifted:

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☑ NO

How many people did you supervise?

What part of your time was spent supervising people?

Did you hire and fire employees? ☐ YES ☑ NO

Were you a lead worker? ☐ YES ☑ NO

EXHIBIT NO. 1E
PAGE: 5 OF 8

Give us more information about Job No. 5 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 5 SUPPLY CLERK ARMY

Rate of Pay	Per (Check One)	Hours per day	Days per week
	☐ Hour ☐ Day ☐ Week ☑ Month ☐ Year	12	7

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

I PROCESSED PARTS FOR MILITARY HEAVY MACHINERY. I WORKED IN A DISTRIBUTION CENTER WHERE WE STORED, SHIPPED, AND PROCESSED PARTS NEEDED FOR THE EQUIPMENT. WHEN THE SHIPMENT ARRIVED, WE UNLOADED THE TRUCKS WITH FORKLIFT AND PALLET JACKS. I SET UP FIELD TRAINING TO PREPARE MYSELF AND SOLDIERS FOR DEPLOYMENT.

In this job, did you:			
	Use machines, tools or equipment?	☑ YES	☐ NO
	Use technical knowledge or skills?	☑ YES	☐ NO
	Do any writing, complete reports, or perform duties like this?	☑ YES	☐ NO

In this job, how many total hours each day did you:

Walk?	5 hours	Kneel? *(Bend legs to rest on knees.)*	6 hours (Most of the day)
Stand?	5 hours	Crouch? *(Bend legs back down forward.)*	6 hours (Most of the day)
Sit?	2 hours (Not very often)	Crawl? *(Bend legs to rest on knees.)*	6 hours (Most of the day)
Climb?	1 hour	Handle, grab or grasp big objects?	8 hours or more
Stoop? *(Bend down and forward at waist.)*	6 hours (Most of the day)	Reach?	8 hours or more
		Write, type or handle small objects?	1 hour

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

PACKAGES, PARTS, PAPERS, ORDER FORMS, TENTS, MILITARY GEAR, M16, GAS MASKS, KEVLAR VEST, HELMET

Check the **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☑ Other **30 LBS**

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☑ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☑ NO

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☑ NO

Were you a lead worker? ☐ YES ☑ NO

EXHIBIT NO. 1E
PAGE: 6 OF 8

Give us more information about Job No. 3 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO. 3 COLLECTION AGENT FINANCIAL SERVICE

Rate of Pay	Per (Check One) Hour	Hours per day	Days per week
_____	☑ Hour ☐ Day ☐ Week ☐ Month ☐ Year	8	5

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

I HAD A CASELOAD OF ACCOUNTS THAT I CALLED ON TO PROCESS THE DELINQUENT BALANCE. I NEGOTIATED PAYMENT PAYOFFS WITH THE CUSTOMER. I PROCESSED PAYMENTS, DOCUMENTED THE PAYMENT TO THE ACCOUNT. I COMPLETED FOLLOW UP CALLS WITH THE CUSTOMER TO RESOLVE THE ACCOUNT BALANCE.

In this job, did you:			
	Use machines, tools or equipment?	☐ YES	☑ NO
	Use technical knowledge or skills?	☑ YES	☐ NO
	Do any writing, complete reports, or perform duties like this?	☐ YES	☑ NO

In this job, how many total hours each day did you:

Walk?	0.5 hours	Kneel? *(Bend legs to rest on knees.)*	0 hours (Never)
Stand?	0.5 hours	Crouch? *(Bend legs back down forward.)*	0 hours (Never)
Sit?	7 hours	Crawl? *(Bend legs to rest on knees.)*	0 hours (Never)
Climb?	0 hours (Never)	Handle, grab or grasp big objects?	0 hours (Never)
Stoop? *(Bend down and forward at waist.)*	0 hours (Never)	Reach?	7 hours
		Write, type or handle small objects?	7 hours

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

PAPERS, HEADSET

Check the **heaviest** weight lifted:

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☑ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☑ NO

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☑ NO

Were you a lead worker? ☐ YES ☑ NO

Give us more information about Job No. 6 listed on Page 1. Estimate hours and pay, if you need to.

JOB TITLE NO.

Rate of Pay	Per *(Check One)*	Hours per day	Days per week
_____	☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year	____	____

Describe this job. What did you do all day? *(If you need more space, write in the "Remarks" section.)*

_____

_____

_____

_____

_____

_____

In this job, did you:	Use machines, tools or equipment?	☐ YES	☐ NO
	Use technical knowledge or skills?	☐ YES	☐ NO
	Do any writing, complete reports, or perform duties like this?	☐ YES	☐ NO

In this job, how many total hours each day did you:

Walk?	_____	Kneel? *(Bend legs to rest on knees.)*	_____
Stand?	_____	Crouch? *(Bend legs back down forward.)*	_____
Sit?	_____	Crawl? *(Bend legs to rest on knees.)*	_____
Climb?	_____	Handle, grab or grasp big objects?	_____
Stoop? *(Bend down and forward at waist.)*	_____	Reach?	_____
		Write, type or handle small objects?	_____

Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

_____

_____

_____

_____

Check the **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

Check weight you **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

Were you a lead worker? ☐ YES ☐ NO

SECTION 3 - REMARKS

Use this section for any add any information you did not have space for in the other parts of this form. Show the page number of the part you are continuing.

BE SURE TO COMPLETE THE BOTTOM OF THIS PAGE.

I WAS A FULL TIME AND I HAD NO EMPLOYMENT HISTORY FROM 2003 UNTIL 8/2004.

Name of person completing this form *(Please print)*	Date *(Month, day, year)*	
JEN DERICKSON	10/16/2012	
Address *(Number and street)*	**Email address** *(optional)*	
300 ALLSUP PLACE		
City	**State**	**Zip Code**
BELLEVILLE	IL	62223-8626

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